RESPECT–Mil

RESPECT–Mil

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Summer 2012

GREETINGS FROM THE DIRECTOR

A warm welcome and big thank you for your continued dedication to the RESPECT-Mil mission and the Soldiers we serve during this time of increased needs. I want you to know that our work is of great interest to the new Army Surgeon General, who has requested a regular data feed on the status of our program unique in the Army behavioral health arena. This is due to your commitment, vision, and hard work.

As we move into summer, RESPECT-Mil is currently operating at 34 Army sites and will soon commence at an additional five while being expanded within existing sites. The program continues to evolve and some locations are already integrating with the Patient Centered Medical Home (PCMH) initiative. This evolution has led to rumors such as "Is RESPECT-Mil going away?" as well as many questions and concerns. RESPECT-Mil, while changing over time in form, name, and staffing design, will still provide the framework, staff, and processes for the PCMH Behavioral Health Team (BHT). Under PCMH, Internal Behavioral Health Consultants (IBHCs)—psychologists and social workers—will be assigned to primary care clinics. They will support primary care providers with real-time consults and will provide focused, time-limited interventions to patients. These short interventions may include behavioral activation and mood management strategies, smoking cessation and weight management help, sleep hygiene advice, relaxation training, and the like.

In PCMH clinics, the current RESPECT-Mil Nurse Care Facilitators (RCFs) will be titled Behavioral Health Case Managers (BHCMs) and together with the IBHCs will form the Behavioral Health Team (BHT) in primary care. Where the RESPECT-Mil program supports active duty patients only, PCMH-BHT supports all adult beneficiaries. This additional workload will absorbed by the care provided by the IBHCs, allowing the care managers to focus on individuals expected to benefit from longer term contact. The timeframe for conversion of all primary care clinics to the PCMH model varies by location.

Throughout the transition, the RESPECT-Mil Implementation Team (R-MIT) will continue to support you—whether you are RESPECT-Mil flavored or PCMH-BHT—providing program management, oversight, training, and mentoring assistance as you transition. We at the R-MIT are here to assist you and advocate for you, and we will be in frequent touch with you through an aggressive schedule of site calls, site visits, and other mechanisms.

We will continue to help you demonstrate the positive impact of your work, foster institutional memory, and provide mentoring on new treatment options for the primary care setting. Our five-site, 1500 participant research project, STEPS UP, is actively studying improvements to the RESPECT-Mil system of care using a variety of web- and telephoned-based therapies along with a system of patient preference-based stepped care coordinated in primary care. Results from this research will help you improve care even more.

I am pleased to announce that the R-MIT has added a Health Psychologist Proponent to the team to provide training and guidance to the IBHCs. PHS Commander Anne Dobmeyer joined us in April. Please do not hesitate to contact her or any of the R-MIT proponents should you have any questions or concerns regarding the program.

FIRST-STEPS has been updated to solve the "timing out" problems that many RCFs have experienced. You can expect to receive your Periodic Performance Report twice annually. These reports, drawn from FIRST-STEPS data, are intended to help you maintain high care quality and program fidelity, suggest where performance improvements may be warranted and give command and staff visibility of key program metrics. The more faithful you are to using this tool, the better our analyses will be.

As we continue to gather data and anecdotes from our existing sites, it remains clear that RESPECT-Mil makes a positive difference in the lives of service members, their families and friends. We thank you for your commitment to this program and to their well-being and safety. We ask for your patience during potential growing pains as we undergo the transition to PCMH-BHT. Let us know how you think the program can be improved and the transition made easier. You are our eyes and ears on the ground, so share what you are experiencing with us so we can support you more fully.

FIRST-STEPS TIPS

By Timothy McCarthy, RESPECT-Mil Deputy Director

First, we are happy to announce that FIRST-STEPS has been updated to solve the "timing out" problem that RCFs have experienced. You will no longer have to use the work around published in the last newsletter!

We want to remind you to use FIRST-STEPS consistently. The R-MIT mines FIRST-STEPS along with your monthly reports for information that we aggregate and report back to you (and your chain of command) on a periodic basis. These semi-yearly Periodic Performance Reports are intended to help you stay on track with the implementation and sustainment of the program.

FIRST-STEPS data also provides valuable insight into the value of the program for military leadership. The more complete your use of this important tool, the better and more complete our data will be.

The R-MIT is particularly sensitive to ensuring that adequate safety SOPs and plans are in place so that when suicidality and other severe behavioral health issues are identified at RESPECT-Mil clinics, these patients are speedily assisted. It is essential to the program that these SOPs be followed and that the suicide risk assessments be administered.

The program goal is a firm 0% missed assessments. Thanks for your support.

RESPECT-Mil is a semi-annual publication of the Deployment Health Clinical Center and RESPECT-Mil Implementation Team.
The views and opinions expressed herein are not necessarily those of the DHCC, RESPECT-Mil or DoD.

TRANSITION

PATIENT-CENTERED MEDICAL HOMES IMPROVE CARE FOR ADULTS WITH CHRONIC CONDITIONS

By Thomas E. Oxman, M.D., Professor Emeritus, Department of Psychiatry, Dartmouth Medical School

Patients with complex chronic conditions account for a disproportionate share of health care costs often with poor outcomes. To address such issues, medical care is being redesigned in the Army and across the military using the Patient-Centered Medical Home (PCMH) model. The Commonwealth Fund recently completed a survey of patients with complex chronic conditions in eleven countries including the United States (Schoen et al: Health Affairs 2011; 30: 2437-2448). In all eleven countries care was usually poorly coordinated, except in primary care practices with the attributes of a PCMH.

The survey used computer-assisted telephone interviews with a common questionnaire to identify adults who met at least one of these characteristics: rated their health as fair or poor; received care for a serious chronic illness, injury, or disability in the past year; reported having had surgery in the past two years; or having been hospitalized in the past two years. Those considered to have a medical home reported that they had a primary care source that knows them, is accessible, and helps coordinate care.

In general, difficulties paying for care or forgoing care were greater for patients in the U.S. compared to the other ten countries (Australia, Canada, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, and United Kingdom). Except for in the U.K., 25% to 50% of patients were taking more than one medication, reported that their medications had not been reviewed in the past year and that their doctor did not spend enough time with them, encourage them to ask questions, or explain things in a way that is easy to understand.

About half of sicker patients in the U.S. were considered to have a medical home. Compared to those without a medical home, these patients received more help in coordinating care, better information flow between specialists and primary care practices, greater availability of records and tests, and the absence of duplicate tests. Medical home patients with hypertension were more likely to report that their blood pressure was controlled (90% vs. 76%). Medical home patients were also less likely to report medical errors. Not surprisingly, those with medical homes were more likely to rate the quality of their care positively.

Table 1 shows a more comprehensive definition of a Patient-Centered-Medical Home as endorsed by the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Osteopathic Association. Of particular interest to RESPECT-Mil, the table below also demonstrates the features of RESPECT-Mil that help support and fulfill the goals of turning primary care practices into medical homes.

Table 1: Comprehensive Definition of a Patient Centered Medical Home

CHARACTERISTIC	DEFINITION	RESPECT-MIL
Personal Physician	Each patient has ongoing relationship with clinician of first contact providing continuous and comprehensive care	PCMs as center of process of care for depression and PTSD
Clinician Directed Practice	Clinician leads a team of individuals who collectively take responsibility for care	PCM as leader of the three component model
Whole-Person Orientation	Clinician responsible for all health care needs or appropriately arranging specialty care	Referral to Behavioral Health as needed
Coordinated & Integrated Care	Facilitated by registries and information technology so that patients get care when and where they need and want it	FIRST-STEPS and Care Manager
Quality & Safety Paramount	Evidence-based medicine and clinical decision support tools; Continuous Quality Improvement (CQI); shared decision making	Treatment recommendations by Behavioral Health Specialist; CQI by R-MIT
Enhanced Access	Open scheduling, expanded hours, options for communication	Care Manager calls, appointment scheduling, and reminders
Payment	Charges recognize added value of PCMH to patients	

PROGRAM DATA

RESPECT-Mil by the NUMBERS

By Leonel Baliton
RESPECT-Mil Program Evaluation and Information Technology Specialist
and
Sheila Barry
RESPECT-Mil Associate Director, Program Development

We are pleased to inform you that RESPECT-Mil continues to be a very successful program due to the hard work and effort of the program's Champions, Care Facilitators and Administrative Assistants. We wish to remind you that each and every day work you do results in the identification of our service members' previously unidentified or previously unresolved behavioral health issues. Your efforts include the detection of service members who are experiencing suicidal ideation at the time they come to your clinic and helping them into care. You are saving lives on a regular basis! Always remember that when you help to improve or save service member's life or career by identifying and properly managing his or her behavioral health concerns your helpful actions are no different than saving his or her life or career under any other circumstance.

Here are the most recent program data that numerically demonstrate continued RESPECT-Mil success:

- RESPECT-Mil has now been implemented at all 37 of 37 designated U.S. Army installations!
- RESPECT-Mil is now also being implemented at the first Navy installation as part of our Tri-Service expansion.
- Through May 2012, 1,914,708 primary care visits were screened for PTSD and depression (~25,529 per month since program inception in 2007). The percentage of primary care visits that are screened as a percentage of all visits has risen consistently to a high of 94% last month.
- Of screened visits since inception, ~ 246,493 (12.8%) are positive. Of screen positive visits, 47.8% are associated with a depression or possible PTSD diagnosis, and 33,845 of screened visits (1.77%) have involved suicidality.
- We continue to receive regular reports of service members being identified as having suicidal ideation by either the screening process or care facilitation—and your leading them to receiving the behavioral health assistance they require.

EDUCATION

TO V OR NOT TO V? THAT IS THE QUESTION

By David Dobson, M.D.
RESPECT-Mil, Tri-Service Behavioral Health Proponent

There has been some confusion on how primary care providers should code for behavioral health problems. Should they code for the diagnosis, use a V code (V79.8) or both? What if there is no diagnosis? First, some basic facts about V codes, and how they should be used in primary care.

What are V codes?

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), is the official system used in the U.S. to classify and assign codes to health conditions and related information. V codes are used in coding for factors influencing health status and contact with health services. Simply, they are used to identify encounters for reasons other than illness or injury.

What is V79.8 and when is it used?

V79.8 is designated for Special screening for other specified mental disorders and developmental handicaps and has specific criteria for its use.

1. V79.8 is used only when a patient has no identified Behavioral Health diagnosis.
2. It can't be used in conjunction with any Behavioral Health diagnosis.

So what does this mean for providers?

The only time you should code using V79.8 is if the patient has no identified Behavioral Health diagnosis and has screened negative for both depression and/or PTSD. A possible decision tree for coding RESPECT-Mil patient encounters would look something like this:

The MEDCOM 774 is given to the patient at the front desk.

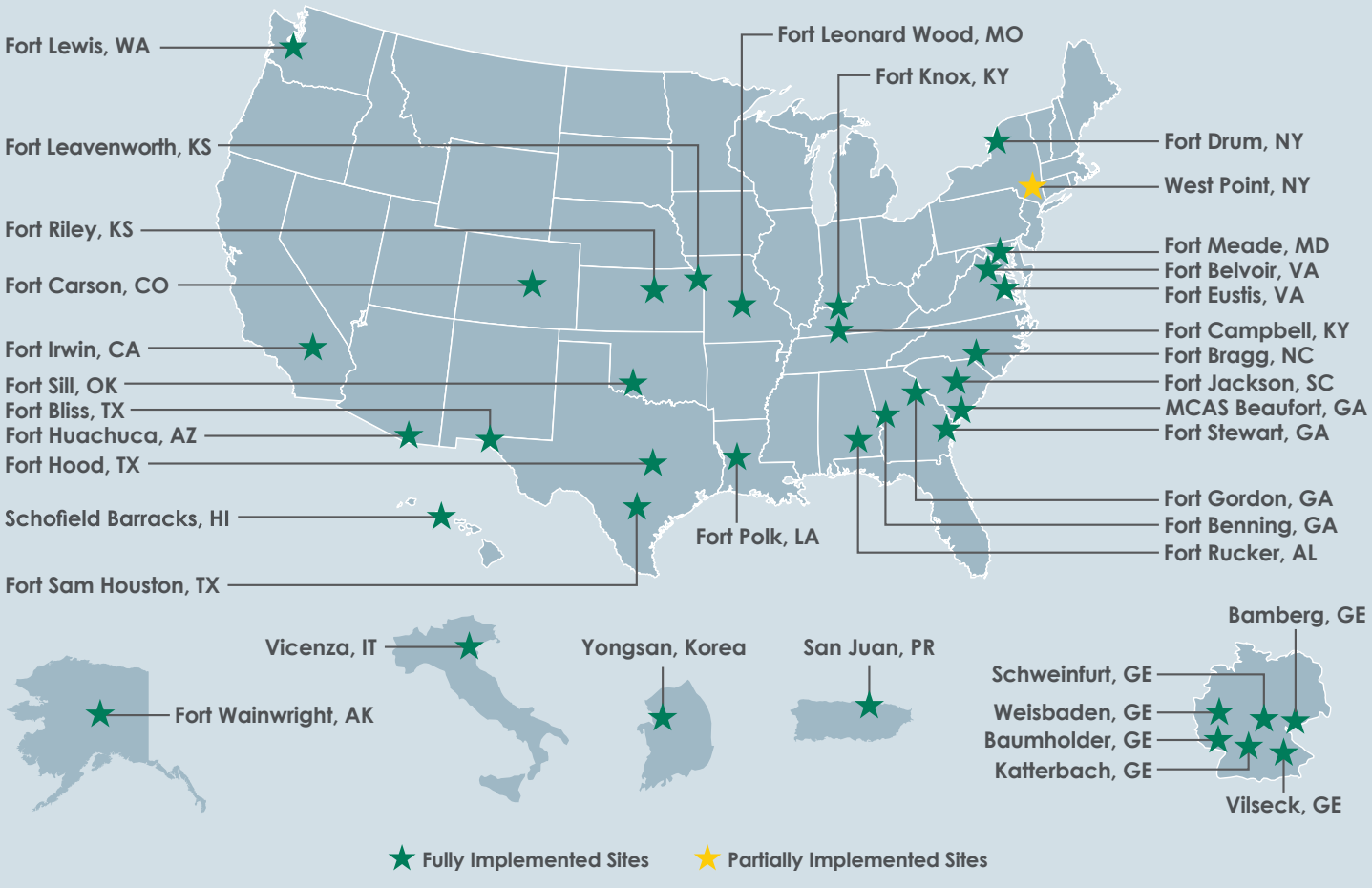
1. Patient screens Negative, and the clinical exam is Negative, then provider should use V79.8.
2. Patient screens Positive, but the clinical exam is Negative, then provider should use V79.8 only if it is determined that there is no Behavioral Health diagnosis.
3. Patient screens Positive and the clinical exam is Positive, then provider should NOT use V79.8, instead he/she should use the appropriate diagnosis code for the Behavioral Health diagnosis (Depression, PTSD, etc).
4. Patient screens Negative but clinical exam is Positive, then providers should NOT use V79.8, instead they should use the appropriate diagnosis code for the Behavioral Health diagnosis (Depression, PTSD, etc).

Can Primary care providers code for both medical and behavioral health problems during the same patient visit?

Yes. If a patient is seen for both HTN and Depression, the provider can code for both conditions that are managed on that visit. In addition, E/M leveling points are added for positive mental health screens (Box A1) and mental health treatments (Box A2) based on those positive screens.

I hope that this answers some of the questions related to coding. Please do not hesitate to contact me if you have questions at david.dobson@med.navy.mil.

RESPECT-MIL WORLDWIDE SITES



RESPECT-Mil Care Facilitator Shannon Young

Shannon Young, RESPECT-Mil Care Facilitator, has been with the program since initial implementation at Fort Campbell in 2008. Ms. Young has served to positively represent the program with leadership, primary care providers and Soldiers throughout all her work at Fort Campbell. She has the respect of her peers and leadership alike.

Fort Campbell's Primary Care Champion, Lt. Col. Lisa Ford, comments, "Shannon has a wonderful rapport with the Providers, as well as the patients. She has full understanding of the RESPECT-Mil program and is an excellent resource/preceptor for the other Care Facilitators, as well as the Administrative Assistants. She is a vital member of the team, and I am blessed to have her here at Fort Campbell."

We recognize and thank Ms. Young for her continued contributions to the success of the RESPECT-Mil program at Fort Campbell, the excellent care she provides her Soldiers, and her dedication to her job, which make her a superior role model for all.

Dr. Melissa Molina Receives Certificate of Appreciation

Congratulations to Dr. Melissa Molina who received a Certificate of Appreciation recently for her work with RESPECT-Mil. Dr. Molina is one of the original site Primary Care Champions for RESPECT-Mil worldwide, sharing longevity with Dr. Allen Swan from Fort Stewart.

Dr. Molina has been a Champion of Champions, serving as a spokesperson at CONUS and OCONUS training sessions for RESPECT-Mil. She has collaborated with and mentored new Champions as they face and overcome local challenges at their sites. Dr. Molina's expertise and dedication remain personally invested in the ongoing management and development of the program at Fort Bliss, TX, where she Chief of Primary Care at William Beaumont Army Medical Center. The development of the screening protocol established at Fort Bliss still serves as a model for replication at other RESPECT-Mil sites.

Thank you Dr Melissa Molina for your longstanding support and your important contributions, which have made RESPECT-Mil a success!

Right: Dr. Melissa Molina, RESPECT-Mil Primary Care Champion and Chief of Primary Care at William Beaumont Army Medical Center, Fort Bliss, TX receiving an award from COL Charles Engel, RESPECT-Mil Director and Director of the DoD Deployment Health Clinical Center.

CDR Anne C. Dobmeyer, Ph.D., ABPP Joins the R-MIT

The RESPECT-Mil Implementation Team (R-MIT) is extremely pleased to announce that Commander Anne Dobmeyer, Ph.D., ABPP, has recently joined the team as the Psychology Proponent, Patient-Centered Medical Home (PCMH) – Behavioral Health Implementation Team (BHIT). Dr. Dobmeyer is a clinical health psychologist in the U.S. Public Health Service. She is also President-Elect of the American Board of Clinical Health Psychology.

Dr. Dobmeyer brings 12 years of active involvement in implementation and training in collaborative care to the R-MIT. She has successfully established fully integrated primary care behavioral health services in family medicine, internal medicine, and women's health clinics in several major Air Force (AF) medical centers, and has served as a consultant to the AF and the DoD on integrated primary care initiatives. She has extensive experience conducting national presentations and workshops on integrated care. Her publications focus on training models and clinical implementation. She is a co-author of the book *Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention.*

Dr. Dobmeyer joins the R-MIT as it transitions to become the PCMH – BH Implementation Team to assist with the upcoming changes that will be occurring in integrated primary care in the DoD. With the transition to Army PCMH, behavioral health services in primary care clinics will involve a blended model of integrated care. The RESPECT-Mil program will continue as the Care Management Model arm of PCMH-BH. This model will be joined by the Primary Care Behavioral Health (PCBH) model in which behavioral health providers (psychologists, social workers, and psychiatric nurse practitioners) will serve as Internal Behavioral Health Consultants (IBHCs) in Army PCMHs, providing consultation to the PCMH team and focused assessment and intervention with patients. Dr. Dobmeyer will assist with training of the IBHCs, and with ongoing program implementation and evaluation efforts.

Welcome Dr. Dobmeyer!

PROPONENTS

The proponents for the various roles in the RESPECT-Mil, PCMH-BH are available for consultation should you have any questions or concerns:

Behavioral Health Proponent
David Dobson, M.D.
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Psychology Proponent
CDR Anne Dobmeyer, Ph.D., ABPP
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Nursing Proponent
Kelly Williams
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PERSONNEL SPOTLIGHT

Care Facilitator and Administrative Assistant June Training

The most recent RESPECT-Mil Care Facilitator and Administrative Assistant training was held June, 5–7, 2012 at the RESPECT-Mil offices in Silver Spring, Maryland. Six Care Facilitators and three Administrative Assistants participated in the training, learning program background, implementation standards, and metrics reporting. Care Facilitators also completed a day-long computer practicum in FIRST-STEPS, RESPECT-Mil's electronic case tracking system.

Welcome Aboard!

Back Row – Melanie Conners, Administrative Assistant, Fort Leavenworth, Kansas; Yvonne Contreras, Administrative Assistant, Fort Bragg, North Carolina; Daniel Henderson, RCF, Fort Riley, Kansas; Javier Vera, RCF, Fort Bliss, Texas; Kaprise Barkley, RCF, Camp Casey, Korea

Front Row – Valencia Watson-Bramble, RCF, Schofield Barracks, Hawaii; Alexandra Wojciechowski, Administrative Assistant, Fort Riley, Kansas; Jamie Bowen, RCF, Fort Bragg, North Carolina; Caral Peddycoart, RCF, Fort Knox, Kentucky; Kelly Williams, RESPECT-Mil Nurse Proponent

ASK THE DIRECTOR

Recently, Colonel David Gillingham, DO, Family Medicine at Winder Clinic posed a question to Colonel Engel.

Question:

"Need clarification from you on a wrinkle one of my care facilitators brought up. We have patients who are being seen by a variety of behavioral health specialists. As but one example, the service member sitting in front of me with a knee sprain reporting that he is being seen regularly in the Soldier Readiness Service. He may well have a positive Respect-Mil screen, but he is already in the care of a behavioral health specialist - perhaps a psychologist. I am not sure of the value added enrolling him in Respect-Mil. My RCF reports that his instructions were that every individual with a positive screen, with the sole exception of those already seeing a Psychiatrist AND getting medications, should be enrolled. Would appreciate your thoughts."

COL Engel Responds:

I'm always interested in hearing what providers feel about the program, including when you might feel the program is a burden. It's important to me that I know what you are experiencing: the good, the bad, and the ugly. Your perceptions are truly my reality. That's a key reason why we do so much traveling to sites.

First and foremost, the decision to use or not use RESPECT-Mil care facilitation is totally up to the primary care clinician and the patient. There is NEVER a hard and fast requirement (or hint thereof) to enroll someone in RESPECT-Mil care management. Having made that clear, you and the patient, as "the deciders," may want to consider some reasons for sometimes involving a care facilitator, even when at first blush it might seem redundant:

(1) Need to cover a short gap—sometimes if you send a patient to specialty BH care, you may know that there is a wait time before getting seen. Even if the wait time is only 4 weeks, the facilitator would make two follow-up contacts during that time.

(2) Want to "indemnify" specialty connection—in the referral situation above, the facilitator can increase the likelihood "the eagle lands" in specialty care (50% don't in civilian studies—suspect probably even higher in active duty). Facilitators are trained to do this through rapport and collaboration and to avoid pressuring or coercive tactics that might ruin subsequent adherence or taint their impression of BH services in the future. Specialists have to force some patients into care for various reasons (acutely suicidal or violent), but those are not the ones in question here.

(3) Want feedback about compliance—sometimes patients you send to specialty care don't take their medicine, don't attend treatment or aren't sure "any of this" will work. The facilitator can help to address misconceptions with the patient, review side effects of meds or discuss what treatments they think will work for them and make the team aware (the specialist or the primary care doc). They are specifically trained to assess these things, and we track them centrally to make sure they do.

(4) Want to know if the patient's not improving—specialists and primary care docs alike may sometimes start a med or initiate group or individual counseling, then lose track of the patient or not "eyeball" the patient once a month to decide if things are "copacetic." Care facilitators are trained (and again, we track performance) to use brief valid scales assessing symptoms, function, suicidality, and treatment adherence that neither you nor the specialist have time or energy to do. These can identify when patients need a change in treatment plan because the old plan isn't working in spite of appearances.

(5) Continuity is a concern—the facilitator's creed as we teach it is essentially "FIRST, never lose track of the patient unless they tell you to stop." They aren't to let patients' "vote with their feet" -- meaning (a) they tell the patient up front, "my mission is to stay in touch with you and help you think about ways to get better. I will assume you still want to do this unless you tell me that you'd like to stop. If you tell me you'd like to stop, then we will stop," and (b) they don't stop trying to contact the patient just because the patient doesn't answer their phone. I can tell you from personal experience that specialists lose track of their patients too, and SHOULD relish a little insurance.

(6) Need help with "watchful waiting"—though not really the focus of your question, some patients as you well know aren't real sure they want to do anything to get better. Ask 'em if it's okay if you have a nurse follow-up with them for "chicken soup and TLC." You'll sleep well knowing that a specialist hears about them at least monthly if not more and you'll get some feedback if the situation changes, hopefully for the better.

All that said, I return to the basic message: whether you think the patient needs any of that or not is your judgment call to make, most often of course with the patient's input. Patient burden is an essential consideration (though historically most of our problems have to do with inadequate resources rather than over treatment). Bottom line: there are no such thing as "thus and such a patient SHOULD be enrolled" in RESPECT-Mil. The program exists to make you and the patient effective. Use it when you think it will help you or the patient.

RESPECT–Mil

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RESPECT-MIL IN THE NEWS

PTSD Outcomes Improve as U.S. Army Adds Behavioral Health Screening to Primary Care

American Soldiers are reaping the rewards of an innovative Army program designed to identify and treat Soldiers at risk of post-traumatic stress disorder (PTSD) or depression earlier by conducting behavioral health screening at all primary care visits. During the American Psychiatric Association's annual meeting last month, Col. Charles Engel, M.D., M.P.H., described the RESPECT-Mil program and its results to date in his presentation, "Effective Integrated Mental Health & Primary Care Services in the U.S. Military." Col. Engel is the RESPECT-Mil program director, director of the Department of Defense Deployment Health Clinical Center at Walter Reed National Military Medical Center, and senior scientist at the Center for the Study of Traumatic Stress. He is also associate chair (Research) of the Department of Psychiatry at the Uniformed Services University School of Medicine in Bethesda, Md.

"Making behavioral health screening as standard as a blood pressure check helps defuse any perceived stigma around seeking help for symptoms of PTSD or depression," said Col. Engel. "Early intervention ensures Soldiers get effective help sooner while reducing the use of clinical services for related symptoms like back pain or accidents and emergency room visits from hazardous drinking."

To read the entire article, visit

http://www.sciencecodex.com/ptsd_outcomes_improve_as_us_army_adds_behavioral_health_screening_to_primary_care-92812

RESPECT-MIL CAREER OPPORTUNITIES

The Henry M. Jackson Foundation for the Advancement of Military Medicine (HJF) staffs many RESPECT-Mil positions. Access these job openings at http://www.hjf.org/careers/open-jobs.

Program Operations Manager, RESPECT-Mil

HJF is seeking a Program Operations Manager, RESPECT-Mil to support the Deployment Health Clinical Center (DHCC), located at the Walter Reed National Military Medical Center (WRNMMC) in Bethesda, Maryland. HJF provides scientific, technical and programmatic support services to DHCC.

Job ID 207275

Primary Care Proponent, RESPECT-Mil

HJF is seeking a Primary Care Proponent, RESPECT-Mil to support the Deployment Health Clinical Center (DHCC), located at the Walter Reed Army National Military Medical Center (WRNMMC) in Bethesda, Maryland. HJF provides scientific, technical and programmatic support services to DHCC.

Job ID 206948

Medical Director, RESPECT-MIL

HJF is seeking a Medical Director, RESPECT-MIL to support the Deployment Health Clinical Center (DHCC), located at the Walter Reed National Military Medical Center (WRNMMC) in Bethesda, Maryland. HJF provides scientific, technical and programmatic support services to DHCC.

Job ID 206722

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Would you like to learn more about the Patient Centered Medical Home and other collaborative care systems? Are you interested in receiving a news digest of articles about deployment health concerns, epidemiology, and treatments? Then we invite to subscribe to the Deployment Health Clinical Center's daily email, the Deployment Health News. Please send your request to WRNMMC-DHCCDailyNews@med.navy.mil to have your email address added to the distribution list.